



February 18, 2014

ENGROSSED

SENATE BILL No. 294

DIGEST OF SB 294 (Updated February 18, 2014 9:57 am - DI 96)

Citations Affected: IC 22-3.

Synopsis: Worker's compensation. Changes the worker's compensation and occupational diseases compensation law by providing that: (1) a medical service provider may not be reimbursed for more than one office visit for each repackaged legend drug prescribed; (2) the maximum period during which a medical service provider that is not a retail or mail order pharmacy may receive reimbursement for a repackaged legend drug begins on the date of the injury or disablement and ends at the beginning of the eighth day after the date of the injury or disablement; and (3) for purposes of determining pecuniary liability, a medical service provider is distinguished from a medical service facility on the basis of the provider's billing form for Medicare reimbursement. Removes language that provides that the reimbursement for an implant may not exceed the invoice amount plus 25%.

Effective: July 1, 2014.

Boots, Buck, Tallian

(HOUSE SPONSORS — OBER, LEHMAN)

January 14, 2014, read first time and referred to Committee on Pensions and Labor.
January 30, 2014, amended, reported favorably — Do Pass.
February 3, 2014, read second time, ordered engrossed. Engrossed.
February 4, 2014, read third time, passed. Yeas 48, nays 0.

HOUSE ACTION

February 10, 2014, read first time and referred to Committee on Employment, Labor and Pensions.
February 18, 2014, amended, reported — Do Pass.

ES 294—LS 6828/DI 102



February 18, 2014

Second Regular Session 118th General Assembly (2014)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type~~.

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~this style type~~ reconciles conflicts between statutes enacted by the 2013 Regular Session and 2013 First Regular Technical Session of the General Assembly.

ENGROSSED SENATE BILL No. 294

A BILL FOR AN ACT to amend the Indiana Code concerning labor and safety.

Be it enacted by the General Assembly of the State of Indiana:

- 1 SECTION 1. IC 22-3-3-4.5, AS ADDED BY P.L.275-2013,
2 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2014]: Sec. 4.5. (a) As used in this section, "legend drug" has
4 the meaning set forth in IC 25-26-14-7.
5 (b) As used in this section, "repackage" has the meaning set forth in
6 IC 25-26-14-9.3.
7 (c) This subsection does not apply to a retail or mail order
8 pharmacy. Except as provided in subsection (d), whenever a
9 prescription covered by IC 22-3-2 through IC 22-3-6 is filled using a
10 repackaged legend drug:
11 (1) the maximum reimbursement amount for the repackaged
12 legend drug must be computed using the average wholesale price
13 set by the original manufacturer for the legend drug;
14 (2) the medical service provider may not be reimbursed for

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1 **more than one (1) office visit for each repackaged legend drug**
2 **prescribed; and**

3 **(3) the maximum period during which a medical service**
4 **provider may receive reimbursement for a repackaged legend**
5 **drug begins on the date of the injury and ends at the**
6 **beginning of the eighth day after the date of the injury.**

7 (d) If the National Drug Code (established under Section 510 of the
8 federal Food, Drug, and Cosmetic Act, 21 U.S.C. 360) for a legend
9 drug cannot be determined from the medical service provider's billing
10 or statement, the maximum reimbursement amount for the repackaged
11 legend drug under subsection (c) is the lowest cost generic for that
12 legend drug.

13 SECTION 2. IC 22-3-3-5.2, AS AMENDED BY P.L.275-2013,
14 SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
15 JULY 1, 2014]: Sec. 5.2. (a) A billing review service shall adhere to
16 the following requirements to determine the pecuniary liability of an
17 employer or an employer's insurance carrier for a specific service or
18 product covered under worker's compensation provided before July 1,
19 2014, by all medical service providers, and after June 30, 2014, by a
20 medical service provider that is not a medical service facility:

21 (1) The formation of a billing review standard, and any
22 subsequent analysis or revision of the standard, must use data that
23 is based on the medical service provider billing charges as
24 submitted to the employer and the employer's insurance carrier
25 from the same community. This subdivision does not apply when
26 a unique or specialized service or product does not have sufficient
27 comparative data to allow for a reasonable comparison.

28 (2) Data used to determine pecuniary liability must be compiled
29 on or before June 30 and December 31 of each year.

30 (3) Billing review standards must be revised for prospective
31 future payments of medical service provider bills to provide for
32 payment of the charges at a rate not more than the charges made
33 by eighty percent (80%) of the medical service providers during
34 the prior six (6) months within the same community. The data
35 used to perform the analysis and revision of the billing review
36 standards may not be more than two (2) years old and must be
37 periodically updated by a representative inflationary or
38 deflationary factor. Reimbursement for these charges may not
39 exceed the actual charge invoiced by the medical service
40 provider.

41 (b) This subsection applies after June 30, 2014, to a medical service
42 facility. The pecuniary liability of an employer or an employer's



insurance carrier for a specific service or product covered under worker's compensation and provided by a medical service facility is equal to a reasonable amount, which is established by payment of one (1) of the following:

(1) The amount negotiated at any time between the medical service facility and any of the following:

(A) The employer.

(B) The employer's insurance carrier.

(C) A billing review service on behalf of a person described in clause (A) or (B).

(D) A direct provider network that has contracted with a person described in clause (A) or (B).

(2) Two hundred percent (200%) of the amount that would be paid to the medical service facility on the same date for the same service or product under the medical service facility's Medicare reimbursement rate, if an amount has not been negotiated as described in subdivision (1).

~~(e) The payment to a medical service provider for an implant furnished to an employee under IC 22-3-2 through IC 22-3-6 may not exceed the invoice amount plus twenty-five percent (25%).~~

~~(d)~~ (c) A medical service provider may request an explanation from a billing review service if the medical service provider's bill has been reduced as a result of application of the eightieth percentile or of a Current Procedural Terminology (CPT) or Medicare coding change. The request must be made not later than sixty (60) days after receipt of the notice of the reduction. If a request is made, the billing review service must provide:

(1) the name of the billing review service used to make the reduction;

(2) the dollar amount of the reduction;

(3) the dollar amount of the service or product at the eightieth percentile; and

(4) in the case of a CPT or Medicare coding change, the basis upon which the change was made;

not later than thirty (30) days after the date of the request.

~~(e)~~ (d) If, after a hearing, the worker's compensation board finds that a billing review service used a billing review standard that did not comply with subsection (a)(1) through (a)(3), as applicable, in determining the pecuniary liability of an employer or an employer's insurance carrier for a medical service provider's charge for services or products covered under worker's compensation, the worker's compensation board may assess a civil penalty against the billing



1 review service in an amount not less than one hundred dollars (\$100)
2 and not more than one thousand dollars (\$1,000).

3 SECTION 3. IC 22-3-6-1, AS AMENDED BY P.L.275-2013,
4 SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
5 JULY 1, 2014]: Sec. 1. In IC 22-3-2 through IC 22-3-6, unless the
6 context otherwise requires:

7 (a) "Employer" includes the state and any political subdivision, any
8 municipal corporation within the state, any individual or the legal
9 representative of a deceased individual, firm, association, limited
10 liability company, or corporation or the receiver or trustee of the same,
11 using the services of another for pay. A parent corporation and its
12 subsidiaries shall each be considered joint employers of the
13 corporation's, the parent's, or the subsidiaries' employees for purposes
14 of IC 22-3-2-6 and IC 22-3-3-31. Both a lessor and a lessee of
15 employees shall each be considered joint employers of the employees
16 provided by the lessor to the lessee for purposes of IC 22-3-2-6 and
17 IC 22-3-3-31. If the employer is insured, the term includes the
18 employer's insurer so far as applicable. However, the inclusion of an
19 employer's insurer within this definition does not allow an employer's
20 insurer to avoid payment for services rendered to an employee with the
21 approval of the employer. The term also includes an employer that
22 provides on-the-job training under the federal School to Work
23 Opportunities Act (20 U.S.C. 6101 et seq.) to the extent set forth in
24 IC 22-3-2-2.5. The term does not include a nonprofit corporation that
25 is recognized as tax exempt under Section 501(c)(3) of the Internal
26 Revenue Code (as defined in IC 6-3-1-11(a)) to the extent the
27 corporation enters into an independent contractor agreement with a
28 person for the performance of youth coaching services on a part-time
29 basis.

30 (b) "Employee" means every person, including a minor, in the
31 service of another, under any contract of hire or apprenticeship, written
32 or implied, except one whose employment is both casual and not in the
33 usual course of the trade, business, occupation, or profession of the
34 employer.

35 (1) An executive officer elected or appointed and empowered in
36 accordance with the charter and bylaws of a corporation, other
37 than a municipal corporation or governmental subdivision or a
38 charitable, religious, educational, or other nonprofit corporation,
39 is an employee of the corporation under IC 22-3-2 through
40 IC 22-3-6. An officer of a corporation who is the sole officer of
41 the corporation is an employee of the corporation under IC 22-3-2
42 through IC 22-3-6, but may elect not to be an employee of the



1 corporation under IC 22-3-2 through IC 22-3-6. If an officer
 2 makes this election, the officer must serve written notice of the
 3 election on the corporation's insurance carrier and the board. An
 4 officer of a corporation who is the sole officer of the corporation
 5 may not be considered to be excluded as an employee under
 6 IC 22-3-2 through IC 22-3-6 until the notice is received by the
 7 insurance carrier and the board.

8 (2) An executive officer of a municipal corporation or other
 9 governmental subdivision or of a charitable, religious,
 10 educational, or other nonprofit corporation may, notwithstanding
 11 any other provision of IC 22-3-2 through IC 22-3-6, be brought
 12 within the coverage of its insurance contract by the corporation by
 13 specifically including the executive officer in the contract of
 14 insurance. The election to bring the executive officer within the
 15 coverage shall continue for the period the contract of insurance is
 16 in effect, and during this period, the executive officers thus
 17 brought within the coverage of the insurance contract are
 18 employees of the corporation under IC 22-3-2 through IC 22-3-6.

19 (3) Any reference to an employee who has been injured, when the
 20 employee is dead, also includes the employee's legal
 21 representatives, dependents, and other persons to whom
 22 compensation may be payable.

23 (4) An owner of a sole proprietorship may elect to include the
 24 owner as an employee under IC 22-3-2 through IC 22-3-6 if the
 25 owner is actually engaged in the proprietorship business. If the
 26 owner makes this election, the owner must serve upon the owner's
 27 insurance carrier and upon the board written notice of the
 28 election. No owner of a sole proprietorship may be considered an
 29 employee under IC 22-3-2 through IC 22-3-6 until the notice has
 30 been received. If the owner of a sole proprietorship:

31 (A) is an independent contractor in the construction trades and
 32 does not make the election provided under this subdivision,
 33 the owner must obtain a certificate of exemption under
 34 IC 22-3-2-14.5; or

35 (B) is an independent contractor and does not make the
 36 election provided under this subdivision, the owner may obtain
 37 a certificate of exemption under IC 22-3-2-14.5.

38 (5) A partner in a partnership may elect to include the partner as
 39 an employee under IC 22-3-2 through IC 22-3-6 if the partner is
 40 actually engaged in the partnership business. If a partner makes
 41 this election, the partner must serve upon the partner's insurance
 42 carrier and upon the board written notice of the election. No



1 partner may be considered an employee under IC 22-3-2 through
 2 IC 22-3-6 until the notice has been received. If a partner in a
 3 partnership:

4 (A) is an independent contractor in the construction trades and
 5 does not make the election provided under this subdivision,
 6 the partner must obtain a certificate of exemption under
 7 IC 22-3-2-14.5; or

8 (B) is an independent contractor and does not make the
 9 election provided under this subdivision, the partner may
 10 obtain a certificate of exemption under IC 22-3-2-14.5.

11 (6) Real estate professionals are not employees under IC 22-3-2
 12 through IC 22-3-6 if:

13 (A) they are licensed real estate agents;

14 (B) substantially all their remuneration is directly related to
 15 sales volume and not the number of hours worked; and

16 (C) they have written agreements with real estate brokers
 17 stating that they are not to be treated as employees for tax
 18 purposes.

19 (7) A person is an independent contractor and not an employee
 20 under IC 22-3-2 through IC 22-3-6 if the person is an independent
 21 contractor under the guidelines of the United States Internal
 22 Revenue Service.

23 (8) An owner-operator that provides a motor vehicle and the
 24 services of a driver under a written contract that is subject to
 25 IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 376 to a motor carrier
 26 is not an employee of the motor carrier for purposes of IC 22-3-2
 27 through IC 22-3-6. The owner-operator may elect to be covered
 28 and have the owner-operator's drivers covered under a worker's
 29 compensation insurance policy or authorized self-insurance that
 30 insures the motor carrier if the owner-operator pays the premiums
 31 as requested by the motor carrier. An election by an
 32 owner-operator under this subdivision does not terminate the
 33 independent contractor status of the owner-operator for any
 34 purpose other than the purpose of this subdivision.

35 (9) A member or manager in a limited liability company may elect
 36 to include the member or manager as an employee under
 37 IC 22-3-2 through IC 22-3-6 if the member or manager is actually
 38 engaged in the limited liability company business. If a member or
 39 manager makes this election, the member or manager must serve
 40 upon the member's or manager's insurance carrier and upon the
 41 board written notice of the election. A member or manager may
 42 not be considered an employee under IC 22-3-2 through IC 22-3-6



1 until the notice has been received.

2 (10) An unpaid participant under the federal School to Work
3 Opportunities Act (20 U.S.C. 6101 et seq.) is an employee to the
4 extent set forth in IC 22-3-2-2.5.

5 (11) A person who enters into an independent contractor
6 agreement with a nonprofit corporation that is recognized as tax
7 exempt under Section 501(c)(3) of the Internal Revenue Code (as
8 defined in IC 6-3-1-11(a)) to perform youth coaching services on
9 a part-time basis is not an employee for purposes of IC 22-3-2
10 through IC 22-3-6.

11 (12) An individual who is not an employee of the state or a
12 political subdivision is considered to be a temporary employee of
13 the state for purposes of IC 22-3-2 through IC 22-3-6 while
14 serving as a member of a mobile support unit on duty for training,
15 an exercise, or a response, as set forth in IC 10-14-3-19(c)(2)(B).

16 (c) "Minor" means an individual who has not reached seventeen
17 (17) years of age.

18 (1) Unless otherwise provided in this subsection, a minor
19 employee shall be considered as being of full age for all purposes
20 of IC 22-3-2 through IC 22-3-6.

21 (2) If the employee is a minor who, at the time of the accident, is
22 employed, required, suffered, or permitted to work in violation of
23 IC 20-33-3-35, the amount of compensation and death benefits,
24 as provided in IC 22-3-2 through IC 22-3-6, shall be double the
25 amount which would otherwise be recoverable. The insurance
26 carrier shall be liable on its policy for one-half (1/2) of the
27 compensation or benefits that may be payable on account of the
28 injury or death of the minor, and the employer shall be liable for
29 the other one-half (1/2) of the compensation or benefits. If the
30 employee is a minor who is not less than sixteen (16) years of age
31 and who has not reached seventeen (17) years of age and who at
32 the time of the accident is employed, suffered, or permitted to
33 work at any occupation which is not prohibited by law, this
34 subdivision does not apply.

35 (3) A minor employee who, at the time of the accident, is a
36 student performing services for an employer as part of an
37 approved program under IC 20-37-2-7 shall be considered a
38 full-time employee for the purpose of computing compensation
39 for permanent impairment under IC 22-3-3-10. The average
40 weekly wages for such a student shall be calculated as provided
41 in subsection (d)(4).

42 (4) The rights and remedies granted in this subsection to a minor



1 under IC 22-3-2 through IC 22-3-6 on account of personal injury
2 or death by accident shall exclude all rights and remedies of the
3 minor, the minor's parents, or the minor's personal
4 representatives, dependents, or next of kin at common law,
5 statutory or otherwise, on account of the injury or death. This
6 subsection does not apply to minors who have reached seventeen
7 (17) years of age.

8 (d) "Average weekly wages" means the earnings of the injured
9 employee in the employment in which the employee was working at the
10 time of the injury during the period of fifty-two (52) weeks
11 immediately preceding the date of injury, divided by fifty-two (52),
12 except as follows:

13 (1) If the injured employee lost seven (7) or more calendar days
14 during this period, although not in the same week, then the
15 earnings for the remainder of the fifty-two (52) weeks shall be
16 divided by the number of weeks and parts thereof remaining after
17 the time lost has been deducted.

18 (2) Where the employment prior to the injury extended over a
19 period of less than fifty-two (52) weeks, the method of dividing
20 the earnings during that period by the number of weeks and parts
21 thereof during which the employee earned wages shall be
22 followed, if results just and fair to both parties will be obtained.
23 Where by reason of the shortness of the time during which the
24 employee has been in the employment of the employee's employer
25 or of the casual nature or terms of the employment it is
26 impracticable to compute the average weekly wages, as defined
27 in this subsection, regard shall be had to the average weekly
28 amount which during the fifty-two (52) weeks previous to the
29 injury was being earned by a person in the same grade employed
30 at the same work by the same employer or, if there is no person so
31 employed, by a person in the same grade employed in the same
32 class of employment in the same district.

33 (3) Wherever allowances of any character made to an employee
34 in lieu of wages are a specified part of the wage contract, they
35 shall be deemed a part of the employee's earnings.

36 (4) In computing the average weekly wages to be used in
37 calculating an award for permanent impairment under
38 IC 22-3-3-10 for a student employee in an approved training
39 program under IC 20-37-2-7, the following formula shall be used.
40 Calculate the product of:

- 41 (A) the student employee's hourly wage rate; multiplied by
42 (B) forty (40) hours.



The result obtained is the amount of the average weekly wages for the student employee.

(e) "Injury" and "personal injury" mean only injury by accident arising out of and in the course of the employment and do not include a disease in any form except as it results from the injury.

(f) "Billing review service" refers to a person or an entity that reviews a medical service provider's bills or statements for the purpose of determining pecuniary liability. The term includes an employer's worker's compensation insurance carrier if the insurance carrier performs such a review.

(g) "Billing review standard" means the data used by a billing review service to determine pecuniary liability.

(h) "Community" means a geographic service area based on ZIP code districts defined by the United States Postal Service according to the following groupings:

(1) The geographic service area served by ZIP codes with the first three (3) digits 463 and 464.

(2) The geographic service area served by ZIP codes with the first three (3) digits 465 and 466.

(3) The geographic service area served by ZIP codes with the first three (3) digits 467 and 468.

(4) The geographic service area served by ZIP codes with the first three (3) digits 469 and 479.

(5) The geographic service area served by ZIP codes with the first three (3) digits 460, 461 (except 46107), and 473.

(6) The geographic service area served by the 46107 ZIP code and ZIP codes with the first three (3) digits 462.

(7) The geographic service area served by ZIP codes with the first three (3) digits 470, 471, 472, 474, and 478.

(8) The geographic service area served by ZIP codes with the first three (3) digits 475, 476, and 477.

(i) "Medical service provider" refers to a person or an entity that provides services or products to an employee under IC 22-3-2 through IC 22-3-6. Except as otherwise provided in IC 22-3-2 through IC 22-3-6, the term includes a medical service facility.

(j) "Medical service facility" means any of the following that provides a service or product under IC 22-3-2 through IC 22-3-6 **and uses the CMS 1450 (UB-04) form for Medicare reimbursement:**

(1) A hospital (as defined in IC 16-18-2-179).

(2) A hospital based health facility (as defined in IC 16-18-2-180).

(3) A medical center (as defined in IC 16-18-2-223.4).



The term does not include a professional corporation (as defined in IC 23-1.5-1-10) comprised of health care professionals (as defined in IC 23-1.5-1-8) formed to render professional services as set forth in IC 23-1.5-2-3(a)(4) or a health care professional (as defined in IC 23-1.5-1-8) who bills for a service or product provided under IC 22-3-2 through IC 22-3-6 as an individual or a member of a group practice **or another medical service provider that uses the CMS 1500 form for Medicare reimbursement.**

(k) "Pecuniary liability" means the responsibility of an employer or the employer's insurance carrier for the payment of the charges for each specific service or product for human medical treatment provided under IC 22-3-2 through IC 22-3-6, as follows:

(1) This subdivision applies before July 1, 2014, to all medical service providers, and after June 30, 2014, to a medical service provider that is not a medical service facility. Payment of the charges in a defined community, equal to or less than the charges made by medical service providers at the eightieth percentile in the same community for like services or products.

(2) This subdivision applies after June 30, 2014, to a medical service facility. Payment of the charges in a reasonable amount, which is established by payment of one (1) of the following:

(A) The amount negotiated at any time between the medical service facility and any of the following, if an amount has been negotiated:

(i) The employer.

(ii) The employer's insurance carrier.

(iii) A billing review service on behalf of a person described in item (i) or (ii).

(iv) A direct provider network that has contracted with a person described in item (i) or (ii).

(B) Two hundred percent (200%) of the amount that would be paid to the medical service facility on the same date for the same service or product under the medical service facility's Medicare reimbursement rate, if an amount has not been negotiated as described in clause (A).

(l) "Service or product" or "services and products" refers to medical, hospital, surgical, or nursing service, treatment, and supplies provided under IC 22-3-2 through IC 22-3-6.

SECTION 4. IC 22-3-7-9, AS AMENDED BY P.L.275-2013, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 9. (a) As used in this chapter, "employer" includes the state and any political subdivision, any municipal corporation



1 within the state, any individual or the legal representative of a deceased
 2 individual, firm, association, limited liability company, or corporation
 3 or the receiver or trustee of the same, using the services of another for
 4 pay. A parent corporation and its subsidiaries shall each be considered
 5 joint employers of the corporation's, the parent's, or the subsidiaries'
 6 employees for purposes of sections 6 and 33 of this chapter. Both a
 7 lessor and a lessee of employees shall each be considered joint
 8 employers of the employees provided by the lessor to the lessee for
 9 purposes of sections 6 and 33 of this chapter. The term also includes an
 10 employer that provides on-the-job training under the federal School to
 11 Work Opportunities Act (20 U.S.C. 6101 et seq.) to the extent set forth
 12 under section 2.5 of this chapter. If the employer is insured, the term
 13 includes the employer's insurer so far as applicable. However, the
 14 inclusion of an employer's insurer within this definition does not allow
 15 an employer's insurer to avoid payment for services rendered to an
 16 employee with the approval of the employer. The term does not include
 17 a nonprofit corporation that is recognized as tax exempt under Section
 18 501(c)(3) of the Internal Revenue Code (as defined in IC 6-3-1-1(a))
 19 to the extent the corporation enters into an independent contractor
 20 agreement with a person for the performance of youth coaching
 21 services on a part-time basis.

22 (b) As used in this chapter, "employee" means every person,
 23 including a minor, in the service of another, under any contract of hire
 24 or apprenticeship written or implied, except one whose employment is
 25 both casual and not in the usual course of the trade, business,
 26 occupation, or profession of the employer. For purposes of this chapter
 27 the following apply:

28 (1) Any reference to an employee who has suffered disablement,
 29 when the employee is dead, also includes the employee's legal
 30 representative, dependents, and other persons to whom
 31 compensation may be payable.

32 (2) An owner of a sole proprietorship may elect to include the
 33 owner as an employee under this chapter if the owner is actually
 34 engaged in the proprietorship business. If the owner makes this
 35 election, the owner must serve upon the owner's insurance carrier
 36 and upon the board written notice of the election. No owner of a
 37 sole proprietorship may be considered an employee under this
 38 chapter unless the notice has been received. If the owner of a sole
 39 proprietorship:

40 (A) is an independent contractor in the construction trades and
 41 does not make the election provided under this subdivision,
 42 the owner must obtain a certificate of exemption under section



- 1 34.5 of this chapter; or
- 2 (B) is an independent contractor and does not make the
- 3 election provided under this subdivision, the owner may obtain
- 4 a certificate of exemption under section 34.5 of this chapter.
- 5 (3) A partner in a partnership may elect to include the partner as
- 6 an employee under this chapter if the partner is actually engaged
- 7 in the partnership business. If a partner makes this election, the
- 8 partner must serve upon the partner's insurance carrier and upon
- 9 the board written notice of the election. No partner may be
- 10 considered an employee under this chapter until the notice has
- 11 been received. If a partner in a partnership:
- 12 (A) is an independent contractor in the construction trades and
- 13 does not make the election provided under this subdivision,
- 14 the partner must obtain a certificate of exemption under
- 15 section 34.5 of this chapter; or
- 16 (B) is an independent contractor and does not make the
- 17 election provided under this subdivision, the partner may
- 18 obtain a certificate of exemption under section 34.5 of this
- 19 chapter.
- 20 (4) Real estate professionals are not employees under this chapter
- 21 if:
- 22 (A) they are licensed real estate agents;
- 23 (B) substantially all their remuneration is directly related to
- 24 sales volume and not the number of hours worked; and
- 25 (C) they have written agreements with real estate brokers
- 26 stating that they are not to be treated as employees for tax
- 27 purposes.
- 28 (5) A person is an independent contractor in the construction
- 29 trades and not an employee under this chapter if the person is an
- 30 independent contractor under the guidelines of the United States
- 31 Internal Revenue Service.
- 32 (6) An owner-operator that provides a motor vehicle and the
- 33 services of a driver under a written contract that is subject to
- 34 IC 8-2.1-24-23, 45 IAC 16-1-13, or 49 CFR 376, to a motor
- 35 carrier is not an employee of the motor carrier for purposes of this
- 36 chapter. The owner-operator may elect to be covered and have the
- 37 owner-operator's drivers covered under a worker's compensation
- 38 insurance policy or authorized self-insurance that insures the
- 39 motor carrier if the owner-operator pays the premiums as
- 40 requested by the motor carrier. An election by an owner-operator
- 41 under this subdivision does not terminate the independent
- 42 contractor status of the owner-operator for any purpose other than



the purpose of this subdivision.

(7) An unpaid participant under the federal School to Work Opportunities Act (20 U.S.C. 6101 et seq.) is an employee to the extent set forth under section 2.5 of this chapter.

(8) A person who enters into an independent contractor agreement with a nonprofit corporation that is recognized as tax exempt under Section 501(c)(3) of the Internal Revenue Code (as defined in IC 6-3-1-11(a)) to perform youth coaching services on a part-time basis is not an employee for purposes of this chapter.

(9) An officer of a corporation who is the sole officer of the corporation is an employee of the corporation under this chapter. An officer of a corporation who is the sole officer of the corporation may elect not to be an employee of the corporation under this chapter. If an officer makes this election, the officer must serve written notice of the election on the corporation's insurance carrier and the board. An officer of a corporation who is the sole officer of the corporation may not be considered to be excluded as an employee under this chapter until the notice is received by the insurance carrier and the board.

(10) An individual who is not an employee of the state or a political subdivision is considered to be a temporary employee of the state for purposes of this chapter while serving as a member of a mobile support unit on duty for training, an exercise, or a response, as set forth in IC 10-14-3-19(c)(2)(B).

(c) As used in this chapter, "minor" means an individual who has not reached seventeen (17) years of age. A minor employee shall be considered as being of full age for all purposes of this chapter. However, if the employee is a minor who, at the time of the last exposure, is employed, required, suffered, or permitted to work in violation of the child labor laws of this state, the amount of compensation and death benefits, as provided in this chapter, shall be double the amount which would otherwise be recoverable. The insurance carrier shall be liable on its policy for one-half (1/2) of the compensation or benefits that may be payable on account of the disability or death of the minor, and the employer shall be wholly liable for the other one-half (1/2) of the compensation or benefits. If the employee is a minor who is not less than sixteen (16) years of age and who has not reached seventeen (17) years of age, and who at the time of the last exposure is employed, suffered, or permitted to work at any occupation which is not prohibited by law, the provisions of this subsection prescribing double the amount otherwise recoverable do not apply. The rights and remedies granted to a minor under this chapter on



1 account of disease shall exclude all rights and remedies of the minor,
2 the minor's parents, the minor's personal representatives, dependents,
3 or next of kin at common law, statutory or otherwise, on account of any
4 disease.

5 (d) This chapter does not apply to casual laborers as defined in
6 subsection (b), nor to farm or agricultural employees, nor to household
7 employees, nor to railroad employees engaged in train service as
8 engineers, firemen, conductors, brakemen, flagmen, baggagemen, or
9 foremen in charge of yard engines and helpers assigned thereto, nor to
10 their employers with respect to these employees. Also, this chapter
11 does not apply to employees or their employers with respect to
12 employments in which the laws of the United States provide for
13 compensation or liability for injury to the health, disability, or death by
14 reason of diseases suffered by these employees.

15 (e) As used in this chapter, "disablement" means the event of
16 becoming disabled from earning full wages at the work in which the
17 employee was engaged when last exposed to the hazards of the
18 occupational disease by the employer from whom the employee claims
19 compensation or equal wages in other suitable employment, and
20 "disability" means the state of being so incapacitated.

21 (f) For the purposes of this chapter, no compensation shall be
22 payable for or on account of any occupational diseases unless
23 disablement, as defined in subsection (e), occurs within two (2) years
24 after the last day of the last exposure to the hazards of the disease
25 except for the following:

26 (1) In all cases of occupational diseases caused by the inhalation
27 of silica dust or coal dust, no compensation shall be payable
28 unless disablement, as defined in subsection (e), occurs within
29 three (3) years after the last day of the last exposure to the hazards
30 of the disease.

31 (2) In all cases of occupational disease caused by the exposure to
32 radiation, no compensation shall be payable unless disablement,
33 as defined in subsection (e), occurs within two (2) years from the
34 date on which the employee had knowledge of the nature of the
35 employee's occupational disease or, by exercise of reasonable
36 diligence, should have known of the existence of such disease and
37 its causal relationship to the employee's employment.

38 (3) In all cases of occupational diseases caused by the inhalation
39 of asbestos dust, no compensation shall be payable unless
40 disablement, as defined in subsection (e), occurs within three (3)
41 years after the last day of the last exposure to the hazards of the
42 disease if the last day of the last exposure was before July 1, 1985.



(4) In all cases of occupational disease caused by the inhalation of asbestos dust in which the last date of the last exposure occurs on or after July 1, 1985, and before July 1, 1988, no compensation shall be payable unless disablement, as defined in subsection (e), occurs within twenty (20) years after the last day of the last exposure.

(5) In all cases of occupational disease caused by the inhalation of asbestos dust in which the last date of the last exposure occurs on or after July 1, 1988, no compensation shall be payable unless disablement (as defined in subsection (e)) occurs within thirty-five (35) years after the last day of the last exposure.

(g) For the purposes of this chapter, no compensation shall be payable for or on account of death resulting from any occupational disease unless death occurs within two (2) years after the date of disablement. However, this subsection does not bar compensation for death:

(1) where death occurs during the pendency of a claim filed by an employee within two (2) years after the date of disablement and which claim has not resulted in a decision or has resulted in a decision which is in process of review or appeal; or

(2) where, by agreement filed or decision rendered, a compensable period of disability has been fixed and death occurs within two (2) years after the end of such fixed period, but in no event later than three hundred (300) weeks after the date of disablement.

(h) As used in this chapter, "billing review service" refers to a person or an entity that reviews a medical service provider's bills or statements for the purpose of determining pecuniary liability. The term includes an employer's worker's compensation insurance carrier if the insurance carrier performs such a review.

(i) As used in this chapter, "billing review standard" means the data used by a billing review service to determine pecuniary liability.

(j) As used in this chapter, "community" means a geographic service area based on ZIP code districts defined by the United States Postal Service according to the following groupings:

(1) The geographic service area served by ZIP codes with the first three (3) digits 463 and 464.

(2) The geographic service area served by ZIP codes with the first three (3) digits 465 and 466.

(3) The geographic service area served by ZIP codes with the first three (3) digits 467 and 468.

(4) The geographic service area served by ZIP codes with the first



three (3) digits 469 and 479.

(5) The geographic service area served by ZIP codes with the first three (3) digits 460, 461 (except 46107), and 473.

(6) The geographic service area served by the 46107 ZIP code and ZIP codes with the first three (3) digits 462.

(7) The geographic service area served by ZIP codes with the first three (3) digits 470, 471, 472, 474, and 478.

(8) The geographic service area served by ZIP codes with the first three (3) digits 475, 476, and 477.

(k) As used in this chapter, "medical service provider" refers to a person or an entity that provides services or products to an employee under this chapter. Except as otherwise provided in this chapter, the term includes a medical service facility.

(l) As used in this chapter, "medical service facility" means any of the following that provides a service or product under this chapter **and uses the CMS 1450 (UB-04) form for Medicare reimbursement:**

(1) A hospital (as defined in IC 16-18-2-179).

(2) A hospital based health facility (as defined in IC 16-18-2-180).

(3) A medical center (as defined in IC 16-18-2-223.4).

The term does not include a professional corporation (as defined in IC 23-1.5-1-10) comprised of health care professionals (as defined in IC 23-1.5-1-8) formed to render professional services as set forth in IC 23-1.5-2-3(a)(4) or a health care professional (as defined in IC 23-1.5-1-8) who bills for a service or product provided under this chapter as an individual or a member of a group practice **or another medical service provider that uses the CMS 1500 form for Medicare reimbursement.**

(m) As used in this chapter, "pecuniary liability" means the responsibility of an employer or the employer's insurance carrier for the payment of the charges for each specific service or product for human medical treatment provided under this chapter as follows:

(1) This subdivision applies before July 1, 2014, to all medical service providers, and after June 30, 2014, to a medical service provider that is not a medical service facility. Payment of the charges in a defined community, equal to or less than the charges made by medical service providers at the eightieth percentile in the same community for like services or products.

(2) This subdivision applies after June 30, 2014, to a medical service facility. Payment of the charges in a reasonable amount, which is established by payment of one (1) of the following:

(A) The amount negotiated at any time between the medical



1 service facility and any of the following, if an amount has been
 2 negotiated:

3 (i) The employer.

4 (ii) The employer's insurance carrier.

5 (iii) A billing review service on behalf of a person described
 6 in item (i) or (ii).

7 (iv) A direct provider network that has contracted with a
 8 person described in item (i) or (ii).

9 (B) Two hundred percent (200%) of the amount that would be
 10 paid to the medical service facility on the same date for the
 11 same service or product under the medical service facility's
 12 Medicare reimbursement rate, if an amount has not been
 13 negotiated as described in clause (A).

14 (n) "Service or product" or "services and products" refers to
 15 medical, hospital, surgical, or nursing service, treatment, and supplies
 16 provided under this chapter.

17 SECTION 5. IC 22-3-7-17.2, AS AMENDED BY SEA 24-2014,
 18 SECTION 100, IS AMENDED TO READ AS FOLLOWS
 19 [EFFECTIVE JULY 1, 2014]: Sec. 17.2. (a) A billing review service
 20 shall adhere to the following requirements to determine the pecuniary
 21 liability of an employer or an employer's insurance carrier for a specific
 22 service or product covered under this chapter provided before July 1,
 23 2014, by all medical service providers, and after June 30, 2014, by a
 24 medical service provider that is not a medical service facility:

25 (1) The formation of a billing review standard, and any
 26 subsequent analysis or revision of the standard, must use data that
 27 is based on the medical service provider billing charges as
 28 submitted to the employer and the employer's insurance carrier
 29 from the same community. This subdivision does not apply when
 30 a unique or specialized service or product does not have sufficient
 31 comparative data to allow for a reasonable comparison.

32 (2) Data used to determine pecuniary liability must be compiled
 33 on or before June 30 and December 31 of each year.

34 (3) Billing review standards must be revised for prospective
 35 future payments of medical service provider bills to provide for
 36 payment of the charges at a rate not more than the charges made
 37 by eighty percent (80%) of the medical service providers during
 38 the prior six (6) months within the same community. The data
 39 used to perform the analysis and revision of the billing review
 40 standards may not be more than two (2) years old and must be
 41 periodically updated by a representative inflationary or
 42 deflationary factor. Reimbursement for these charges may not



1 exceed the actual charge invoiced by the medical service
2 provider.

3 (b) This subsection applies after June 30, 2014, to a medical service
4 facility. The pecuniary liability of an employer or an employer's
5 insurance carrier for a specific service or product covered under
6 ~~worker's compensation~~ **this chapter** and provided by a medical service
7 facility is equal to a reasonable amount, which is established by
8 payment of one (1) of the following:

9 (1) The amount negotiated at any time between the medical
10 service facility and any of the following:

11 (A) The employer.

12 (B) The employer's insurance carrier.

13 (C) A billing review service on behalf of a person described in
14 clause (A) or (B).

15 (D) A direct provider network that has contracted with a
16 person described in clause (A) or (B).

17 (2) Two hundred percent (200%) of the amount that would be
18 paid to the medical service facility on the same date for the same
19 service or product under the medical service facility's Medicare
20 reimbursement rate, if an amount has not been negotiated as
21 described in subdivision (1).

22 ~~(c) The payment to a medical service provider for an implant~~
23 ~~furnished to an employee under this chapter may not exceed the invoice~~
24 ~~amount plus twenty-five percent (25%).~~

25 ~~(d)~~ (c) A medical service provider may request an explanation from
26 a billing review service if the medical service provider's bill has been
27 reduced as a result of application of the eightieth percentile or of a
28 Current Procedural Terminology (CPT) or Medicare coding change.
29 The request must be made not later than sixty (60) days after receipt of
30 the notice of the reduction. If a request is made, the billing review
31 service must provide:

32 (1) the name of the billing review service used to make the
33 reduction;

34 (2) the dollar amount of the reduction;

35 (3) the dollar amount of the medical service at the eightieth
36 percentile; and

37 (4) in the case of a CPT or Medicare coding change, the basis
38 upon which the change was made;

39 not later than thirty (30) days after the date of the request.

40 ~~(e)~~ (d) If, after a hearing, the worker's compensation board finds that
41 a billing review service used a billing review standard that did not
42 comply with subsection (a)(1) through (a)(3), as applicable, in



determining the pecuniary liability of an employer or an employer's insurance carrier for a medical service provider's charge for services or products covered under occupational disease compensation, the worker's compensation board may assess a civil penalty against the billing review service in an amount not less than one hundred dollars (\$100) and not more than one thousand dollars (\$1,000).

SECTION 6. IC 22-3-7-17.4, AS ADDED BY P.L.275-2013, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2014]: Sec. 17.4. (a) As used in this section, "legend drug" has the meaning set forth in IC 25-26-14-7.

(b) As used in this section, "repackage" has the meaning set forth in IC 25-26-14-9.3.

(c) This subsection does not apply to a retail or mail order pharmacy. Except as provided in subsection (d), whenever a prescription covered by this chapter is filled using a repackaged legend drug:

(1) the maximum reimbursement amount for the repackaged legend drug must be computed using the average wholesale price set by the original manufacturer for the legend drug;

(2) the medical service provider may not be reimbursed for more than one (1) office visit for each repackaged legend drug prescribed; and

(3) the maximum period during which a medical service provider may receive reimbursement for a repackaged legend drug begins on the date of the disablement and ends at the beginning of the eighth day after the date of the disablement.

(d) If the National Drug Code (established under Section 510 of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 360) for a legend drug cannot be determined from the medical service provider's billing or statement, the maximum reimbursement amount for the repackaged legend drug under subsection (c) is the lowest cost generic for that legend drug.



COMMITTEE REPORT

Madam President: The Senate Committee on Pensions and Labor, to which was referred Senate Bill No. 294, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 3, line 13, delete "An amount not to exceed".

Page 3, line 13, reset in roman "Two".

Page 3, line 13, delete "one".

Page 3, line 13, delete "fifty".

Page 3, line 14, reset in roman "(200%)".

Page 3, line 14, delete "(150%)".

Page 3, delete lines 19 through 32.

Page 3, strike lines 33 through 34.

Page 3, line 35, strike "exceed the".

Page 3, line 35, delete "amount of the medical service facility's actual".

Page 3, line 36, delete "acquisition cost as evidenced by an".

Page 3, line 36, strike "invoice".

Page 3, line 36, delete "from the implant".

Page 3, line 37, delete "manufacturer to the medical service facility".

Page 3, line 37, strike "plus twenty-five percent".

Page 3, line 38, strike "(25%)".

Page 3, line 38, delete "The actual acquisition cost must be reduced by the amount".

Page 3, delete lines 39 through 42.

Page 4, delete line 1.

Page 4, line 2, strike "(d)" and insert "(c)".

Page 4, line 17, strike "(e)" and insert "(d)".

Page 10, line 16, delete "The term does".

Page 10, delete lines 17 through 19.

Page 11, line 15, delete "An amount not to exceed".

Page 11, line 15, reset in roman "Two".

Page 11, line 15, delete "one".

Page 11, line 15, delete "fifty".

Page 11, line 16, reset in roman "(200%)".

Page 11, line 16, delete "(150%)".

Page 11, delete lines 21 through 35.

Page 17, line 13, delete "The term does not include a".

Page 17, delete lines 14 through 16.

Page 18, line 12, delete "An amount not to exceed".



Page 18, line 12, reset in roman "Two".
 Page 18, line 12, delete "one".
 Page 18, line 12, delete "fifty".
 Page 18, line 13, reset in roman "(200%)".
 Page 18, line 13, delete "(150%)".
 Page 18, delete lines 18 through 32.
 Page 19, line 36, delete "An amount not to exceed".
 Page 19, line 36, reset in roman "Two".
 Page 19, line 36, delete "one".
 Page 19, line 36, delete "fifty".
 Page 19, line 37, reset in roman "(200%)".
 Page 19, line 37, delete "(150%)".
 Page 19, delete line 42.
 Page 20, delete lines 1 through 13.
 Page 20, strike lines 14 through 15.
 Page 20, delete line 16.
 Page 20, line 17, delete "evidenced by an".
 Page 20, line 17, strike "invoice".
 Page 20, line 17, delete "from the implant manufacturer to".
 Page 20, line 18, delete "the medical service facility".
 Page 20, line 18, strike "plus twenty-five percent (25%)".
 Page 20, line 18, after "(25%)." delete "The".
 Page 20, delete lines 19 through 24.
 Page 20, line 25, strike "(d)" and insert "(c)".
 Page 20, line 40, strike "(e)" and insert "(d)".

and when so amended that said bill do pass.

(Reference is to SB 294 as introduced.)

BOOTS, Chairperson

Committee Vote: Yeas 7, Nays 0.



COMMITTEE REPORT

Mr. Speaker: Your Committee on Employment, Labor and Pensions, to which was referred Senate Bill 294, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 17, line 17, delete "P.L.275-2013," and insert "SEA 24-2014,".

Page 17, line 18, delete "15," and insert "100,".

and when so amended that said bill do pass.

(Reference is to SB 294 as printed January 31, 2014.)

GUTWEIN, Chair

Committee Vote: yeas 11, nays 1.

